

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015793

STATE FILE NUMBER

2 3116

XC 16189744  
SL 18060  
FILED APR 20 1959

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY MADISON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO		c. CITY OR TOWN ALTON	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL		d. STREET ADDRESS (If outside, give location) 2246 E BROADWAY	
3. NAME OF DECEASED (Type or print) First MIKE Middle STOCKERS Last		4. DATE OF DEATH Month MARCH Day 26 Year 1959	
5. SEX MALE 0	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 1 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/84
9. AGE (In years last birthday) 74		10. FUND 1 YEAR Months Days Hours Min.	11. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) GREEKE, GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME JOHN STOCKER		13b. MOTHER'S MAIDEN NAME MARY LOW	
14. NAME OF HUSBAND OR WIFE UNKNOWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give unknown) (If yes, give war or dates of service) YES WW I	
16. SOCIAL SECURITY NO.		17. INFORMANT Address VA HOSP RECORDS 915 N GRAND ST LOUIS, MO.	
18. CAUSE OF DEATH (Write only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHIXATION FROM ASPIRATION OF VOMATUS COMATOSE CONDITION Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PYCLONEPHRITIS DUE TO PROTEUS WITH ACIDOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - 600.0 -		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 4 to 6 HOURS 2 MONTHS	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> NONE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. attended the deceased from 3/2/59 to 3/26/59 and last saw him alive on 3/26/59. Death occurred at 7:35 PM m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE R. Baker, R. BAKER, M.D.	
22b. ADDRESS VAH, ST LOUIS MO		22c. DATE SIGNED 3/26/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-31-59	
23c. NAME OF CEMETERY OR CREMATORY Veterans Adm. Cemetery		23d. LOCATION (City, town, or county) (State) Danville, Illinois	
24. FUNERAL DIRECTOR Staten Funeral Home, 220 Court St. Alton, Ill.		25. DATE RECD. BY LOCAL REG. MAR 27 '59	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed .....

*No Embalmer Lawrence & Meyer*  
Licensed Embalmer No. ....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.